TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
GLORIA G. BOX, MD

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-15-0541-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
OCTOBER 7, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Enclosed is denied claim stating that the previously submitted documentation does not support the services being billed. I am sending additional medical records to support the services being billed. Please review and reconsider for payment."

Amount in Dispute: $4,300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "1. MAVERICK COUNTY HOSPITAL DISTRICT provided emergency department services to the claimant on the date above. 2. Texas Mutual declined to issue payment as the documentation of the treatment failed to substantiate an emergency as defined by Rule 133.2(a)(4)(A)."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 3, 2014	CPT Code 27506-22 Open treatment of femoral shaft fracture, with or without external fixation, with insertion of intramedullary implant, with or without cerclage and/or locking screws	$2,400.00	$0.00
	CPT Code 27530-LT Closed treatment of tibial fracture, proximal (plateau); without manipulation	$700.00	$0.00
	CPT Code 27780-51 Closed treatment of proximal fibula or shaft fracture; without manipulation	$600.00	$0.00
	CPT Code 27786-59 Closed treatment of distal fibular fracture (lateral malleolus); without manipulation	$600.00	$0.00

TOTAL		$4,300.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.2, effective March 30, 2014 defines a medical emergency.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
   - CAC-16-Claim/Service lacks information or has submission/billing error(s) which is needed for adjudication.
   - 876-Required documentation missing or illegible see rules 133.1, 133.210, 129.5, or 180.22.
   - 899-Documentation and file review does not support an emergency in accordance with rule 133.2.
   - CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 891-No additional payment after reconsideration.

Issues

1. Does the requestor's submitted documentation support emergency care per 28 Texas Administrative Code §133.2?
2. Does the submitted medical records support billed service?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon reason code "899."

   28 Texas Administrative Code §133.2(5) defines "Emergency--Either a medical or mental health emergency as follows: (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part; (B) a mental health emergency is a condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person."

   According to the submitted medical records, the claimant was treated in the Emergency Room in Corpus Christi, Texas after sustaining multiple fractures on the job on [date of injury]. The claimant was placed in a padded splint to his lower extremity and was instructed that he would need further treatment once the swelling receded. The records indicate that claimant lived in [city]. Because of the difficulty in travel to Corpus Christi from[city], the injured worker sought treatment at Maverick County Hospital District and examined by Dr. Gloria Box.

   Dr. Box wrote in the June 3, 2014 Orthopedic Consultation Note that the claimant's swelling was "mild" and "moderate". The Orthopedic Consultation Note does not support a medical emergency as defined by 28 Texas Administrative Code §133.2(5). Therefore, the respondent's denial based upon reason code "899" is supported.

2. The respondent also denied reimbursement for the disputed services due to a lack of documentation to support service billed. A review of the submitted documentation finds that the requestor did not submit an Operative Report to support billed service. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		06/25/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.